UCAF 2.0

To be completed and ID verified by the reception/nurse:

Provider Name: ALDAWA MEDICAL SERVICES CO [DAWA]
Insurance Company Name: MedGulf
TPA Company Name: N/A
Patient File Number:
Dept: Pharmacy
Single (✓) Married ( )
Plan Type (C O R P O R A T E)
Date of visit:
New visit (✓) Follow Up ( ) Refill ( ) Walk In ( ) Referral ( )
Approval Date/Time:
Approval Validity: 30 day

Print/Fill in clear letters or Emboss Card:

Insured Name: ABDULRAHMAN MOHAMMAD A ALKHATEEB
ID. Card No: 1454104 National ID:
Sex: Male Age: 68 Years
Policy Holder: SAUDI ELECTRICITY COMPANY - SOUTH
Policy No: GRH/13707419-0
Member Since: 01-01-2021 Member Type: PRINCIPAL
Expiry Date: 01-01-2022 Class: CLASS BPO (CLASS B PARENTS OUTPATIENT ONLY)
Approval: Approval Type: PHARMACY
Approval Reference Number: 2021/2205469
Approval Status: Approved
Message: Granted

To be Completed by the Attending PHYSICIAN: Please tick (✓)

Inpatient ( ) Outpatient ( ) **Emergency Case ( )** | Emergency Care Level: 1( ) 2( ) 3( ) 4( ) 5( )
Physician Name [ID]: [ ]
BP: 120/80 Pulse: Temp: 37 °C Weight: Height: R.R: Duration of Illness: 1 Days
Chief Complaints and Main Symptoms: Medicine Referral
Siginficant Signs:
Possible Line of Treatment:
Other Conditions:
Diagnosis:
Principal Code: R69 2nd Code: 3rd Code: 4th Code:

Please tick (✓) where appropriate:

Chronic (✓) Congenital ( ) RTA ( ) Work Related ( ) Vaccination ( )
Check-up ( ) Psychiatric ( ) Infertility ( ) Pregnancy ( ) Indicate LMP:
Suggestive line(s) of management: Kindly, enumerate the recommended investigations, and/or procedures **For outpatient approvals only:**

Code	Service	Type	Req. Qty	Req. Cost	App. Qty	App. Cost
100936	FUCITHALMIC 5GM EYE DROPS [100936]	N_A	9	141.75	9	141.75
101102	HYFRESH 10ML EYE DROPS [101102]	N_A	4	136.60	4	136.6
101614	OLOPAT EYE DROPS 5ML [101614]	N_A	4	178.8	4	178.8

Providers Approval/Coding Staff must review/code the recommended service(s) and allocate cost and complete the following:
Completed/Coded By. . . . . Signature. . . . . Date . . . ./ . . . ./ . . . .

Medication Name (Generic Name)	Type	Req. Qty	Req. Cost	App. Qty	App. Cost

In case Management Form (CMF1.0) included**Yes ( ) No ( )**
Please specify possible line of management when applicable: . . . .
Estimated Length of stay: a days **Expected date of admission:**
Approved Length of stay: a days **Estimated Cost:**(SAR)457.15 **Total Approved Cost:**(SAR)457.15

Provider Comments:
[Date and Time: 03-06-2021 17:29] AL-DAWAA PHARMACY-P0089 KINLY APPROVE ATTACHED PRESCRIPTION
[Date and Time: 03-06-2021 17:29] Attachment URL: https://waseeler.waseel.com/waseeler/web/xhtml/DMS/ViewAttachment.jsf?id=6842393
Payer Comments:
[Date and Time: 03-06-2021 17:42] APP FOR TTT AS PL
[Date and Time: 03-06-2021 17:29] All Approvals will be subject to Audit and policy terms and conditions
Comment:

I hereby certify that ALL information mentioned are correct and that the medical services shown on this form were medically indicated and necessary for the management of this case.
Physician . . . . Signature . . . . Stamp Date . . . . . / . . . . . / . . . . .

I hereby certify that ALL statements and information provided concerning patient identification and the present illness or injury are TRUE.
Name (and relationship if guardian): . . . .
Signature(*). . . . . . . Date . . . . . / . . . . . / . . . . .

For Insurance Comapny Use Only: Approved ( ) Not Approved ( ) Approval No: 2021/2205469 Approval validity: 30 day
Comments (include approved days/services if different from the requested) . . . .

Approved/Disapproved By . . . . Signature . . . . Date: . . . / . . . / . . .

(*) this is applicable only in case of manual UCAF